LEOFF 1 Medical Benefits

Office of the State Actuary
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We would like to express our appreciation to Charles L. Langen for his work on this report. He facilitated the 1995 LEOFF 1 Medical Study as a member of the Office of the State Actuary, and stepped out of retirement to conduct this study. His expertise, experience and general knowledge of governmental activities was invaluable.

Introduction

In 1994, the Legislature mandated the Office of the State Actuary to perform a study of the medical benefits provided by the Law Enforcement Officers' and Fire Fighters' Plan 1 (LEOFF 1) retirement system. The study was completed and published in 1995.

Five years later, representatives of cities, counties, and fire protection districts remained concerned, primarily due to the passage of Initiative No. 695. They prevailed upon the Legislature to conduct a new study. As a result two directives were enacted. The first directive is found in Chapter 309, Section 105(2), Laws of 1999, where the Office of the State Actuary is directed to do *"an actuarial study of local government liabilities for law enforcement officers' and fire fighters' retirement system medical benefits."*

The second directive is found in Chapter 1, Section 908, Laws of 2000, 2nd Extraordinary Session:

> *"The joint committee on pension policy shall provide for a study, through the office of the state actuary during the 2000 interim, of the options for providing partial funding of law enforcement officers' and fire fighters' retirement system plan 1 retiree medical expenses from the surplus assets of the law enforcement officers' and fire fighters' retirement system plan 1 fund. The study shall include a report by the office of the state actuary on local government liabilities, as required by the 1999-2001 operating budget, and a review of legal issues, federal tax compliance issues, variations in local government benefits and funding mechanisms, and other relevant issues."*

Background Information

Membership

The law enforcement officers, other than the commissioned officers of the Washington State Patrol, and fire fighting personnel of the State of Washington have retirement coverage under one of two plans within the Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF). This discussion will deal only with those members first employed prior to October 1, 1977. These persons constitute the membership of LEOFF 1, the original statewide system. The remainder of the membership constitutes LEOFF 2.

Prior to the initiation of LEOFF 1, individual pension systems were authorized for police officers of First Class Cities and a statewide pension system for municipal fire fighters. Due to potential fiscal liability of the participating employers and a desire to consolidate these several systems, LEOFF 1 was initiated in 1970. One of the benefits carried forward and improved from these several systems to LEOFF 1 was medical services. In the subsequent development of LEOFF 2, however, the medical services benefit was not provided.

The membership of LEOFF 1, as of December 31, 1999, is employed within four categories as shown in Table 1. (Appendix A contains the detailed listing.)

Table 1
LEOFF 1 Employers

Employer Category	Having Active Members	Having Both Active and Retired Members
Counties	33	38
Cities	92	154
Fire Protection Districts	27	57
Port Districts	4	5
Total	156	254

There are 8,296 LEOFF 1 members comprised of 1,743 who are active and 6,553 who are retired for service or disability. Figure 1 reflects the distribution of these members by status and age.

Figure 1
LEOFF 1 Membership

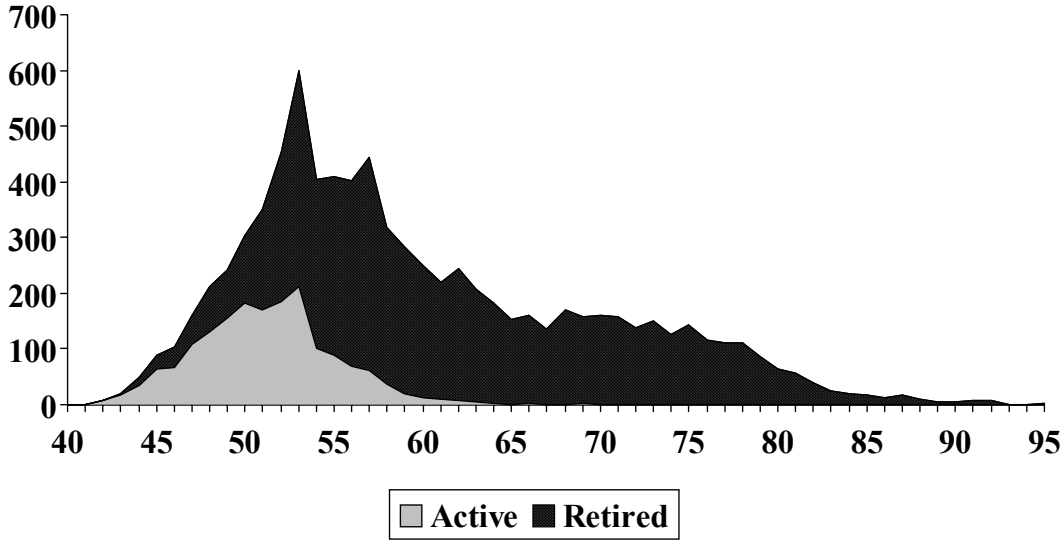


Table 2 shows the average ages of this population compared to 1995, the date of the last study of LEOFF 1 medical benefits. This indicates that although the membership is aging, it still remains relatively young.

Table 2
Comparative Average Ages: 1995 and 1999

	1995	1999
Active Members	47	51
Service Retirees	66	66
Disability Retirees	58	60
All Retirees	60	62
All Members	55	60

The various distributions of the membership are reflected in Table 3 showing current or previous employment and membership status.

Table 3
LEOFF 1 Membership as of December 31, 1999

Employer	Active Members	Service Retirees	Duty Disability Retirees	Non-duty Disability Retirees	Total Retirees	Total Members
Law Enforcement Officers						
Sheriff	248	431	468	151	1,050	1,298
1st Class Cities	395	836	659	167	1,662	2,057
Other Cities	237	322	474	121	917	1,154
Total	880	1,589	1,601	439	3,629	4,509
Fire Fighters						
1st Class Cities	507	397	1,449	79	1,925	2,432
Other Cities	220	230	354	65	649	869
Fire Districts	128	98	144	43	285	413
Port Districts	8	24	27	14	65	73
Total	863	749	1,974	201	2,924	3,787
Grand Total	1,743	2,338	3,575	640	6,553	8,296

Medical Benefit

Statutorily required post-retirement medical benefits is one of the features that distinguishes LEOFF 1 from other State retirement systems. This benefit is set forth in statute as follows:

> *"Whenever any active member, or any member retired . . . on account of . . . sickness . . . not caused or brought on by dissipation or abuse, of which the disability board shall be judge, is confined in any hospital or in home, and whether or not so confined, requires medical services, the employer shall pay . . . the necessary medical services not payable from some other source. . . ." [RCW 41.26.150(1)]*

The statute also sets forth the minimum medical services for which the employer is responsible. These services are:

1. Hospital board and room not to exceed semi-private, unless condition requires otherwise.
2. Hospital services, other than board and room.
3. Fees for:
   a. Licensed physicians or surgeons
   b. Licensed osteopaths; and
   c. Licenced chiropractors.
4. Charges of a registered graduate nurse.
5. Physician-prescribed drugs and medications.
6. X-ray, radium, and radioactive isotopes therapy.
7. Anesthesia and oxygen.
8. Rental of durable medical and surgical equipment.
9. Artificial limbs and eyes, and casts, splints and trusses.
10. Professional ambulance services to transport to or from a hospital.
11. Dental charges resulting from accidental injury to the teeth if treatment is commenced within 90 days of the accident.
12. Nursing home confinement or hospital extended care facility.
13. Physical therapy by a registered physical therapist.
14. Blood transfusions.
15. Licensed optometric examination.

Prior to July 1, 2000, the cost of the LEOFF 1 pension retirement system was shared: the member and employer each paid six percent of the member's salary and the State paid the remainder. This remainder was quite significant from 1970 into the 1980s, when upwards of 35 percent of salary was required to be paid by the State. From July 1, 2000 forward, if the system remains fully funded, the employee and employer will not make a contribution as long as the plan has no unfunded liability. The State has not been required to make a contribution since July 1, 1999. The individual local government employer is fully responsible for all medical costs. The last employer of a retired LEOFF 1 member is responsible for all post-retirement medical benefits.

Disability Boards

Disability boards are a key aspect of the LEOFF 1 system. They perform the dual functions of (a) determining duty or non duty disability for the purpose of leave or retirement and (b) approving medical benefits for active and retired members. These boards have their origin in police and fire fighter retirement systems in effect prior to the establishment of LEOFF. With the establishment of LEOFF the existing boards were retained and others created to handle the expanded membership.

There are 80 autonomous disability boards in the state divided into three types. Each of the ten First Class Cities have two boards, one each for law enforcement officers and fire fighters. These cities are:

Aberdeen	Seattle
Bellingham	Spokane
Bremerton	Tacoma
Everett	Vancouver
Richland	Yakima

The active and retired law enforcement officers and fire fighters each have their own board. There are 20 boards for First Class Cities.

Each of these law enforcement (or police) boards have seven members. They are:

- The Mayor or the Mayor's designated representative who shall be an elected official.
- The City Clerk.
- The City Treasurer
- The President of the City Council or the Mayor pro tempore.
- Three active or retired law enforcement members elected by the law enforcement membership of the city.

Each of the fire fighter boards have five members. They are:

- Ex officio, the Mayor or the Mayor's designated representative who shall be an elected city official
- The City Comptroller or the City Clerk
- The Chair of the City Council Finance Committee
- Two active or retired fire fighters elected by the fire fighters of the city.

There are 21 boards for cities with 20,000 or more population. The cities are:

Auburn	Mountlake Terrace
Bellevue	Olympia
Bothell	Pasco
Edmonds	Pullman
Kennewick	Puyallup
Kent	Redmond
Kirkland	Renton
Lacey	SeaTac
Longview	Walla Walla
Lynnwood	Wenatchee
Mercer Island	

There is one board for both law enforcement and fire fighters in each of these cities. The membership is composed of the following:

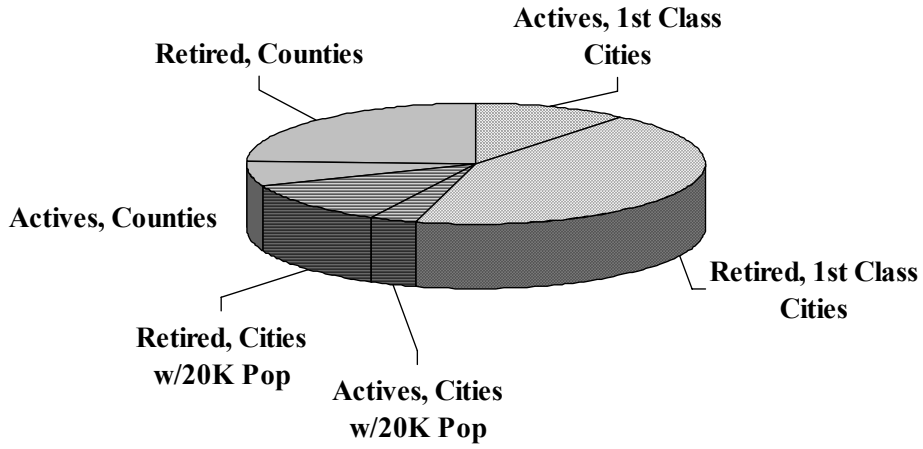
- Two members of the city legislative body appointed by the Mayor
- One active or retired law enforcement officer of the city
- One active or retired fire fighter of the city
- One city resident selected by the other four members.

Finally, there are the county boards. These boards serve the affected LEOFF 1 members within the respective County not employed by or retired from a city having a disability board. This would include County Sheriff Departments, 124 cities, 57 Fire Protection Districts and 5 Port Districts. Each county board membership consists of:

- One member of the County's legislative body who is appointed by this body
- One member of a city or town legislative body elected by the mayors of the cities and towns within the County not having a disability board. If, however, the County has a population under 60,000, a non-elected citizen of the county may be appointed.
- One active or retired law enforcement officer elected by the law enforcement officers of the County who are not under the jurisdiction of a city disability board
- One active or retired fire fighter elected by the fire fighters who are not under the jurisdiction of a city disability board
- One resident of the county, not residing in a city with a disability board, selected by the other four members.

The LEOFF 1 membership is distributed among these boards as shown in Figure 2. Appendix B provides the specific employer make-up and member distribution among the disability boards.

Figure 2
LEOFF 1 Distribution of Members
As of December 31, 1999



A board's authority is specified in RCW 41.26.150:

> *"(1) Whenever any active member, or any member hereafter retired, on account of service, sickness, or disability, not caused or brought on by dissipation or abuse, of which the disability board shall be judge, is confined in any hospital or in home, and whether or not so confined, requires medical services, the employer shall pay for the active or retired member the necessary medical services not payable from some other source. . . .*
>
> *"(a) The disability board in all cases may have the active or retired member suffering from such sickness or disability examined at any time by a licensed physician or physicians, to be appointed by the disability board, for the purpose of ascertaining the nature and extent of the sickness or disability . . . .*
>
> *"(b) The disability board shall designate the medical services available to any sick or disabled member." [Emphasis added]*

As can be seen in this statute, these boards have great discretionary power as to the medical services benefit. The services expressly stated must certainly be provided, but the boards have the right to expand on them or, possibly, limit the extent of the services.

Insurance

Employers generally control the risk and administration of these medical services through the use of insurance. This is expressly the desire of the Legislature as set forth again in RCW 41.26.150:

"(2) The medical services payable under this section will be reduced by any amount received or eligible to be received by the member under workers' compensation, social security . . . insurance provided by another employer, other pension plan, or any other similar source. . . .

"(4) Any employer under this chapter, either singly, or jointly with any other such employer or employers through an association thereof . . .may provide for all or part of one or more plans of group hospitalization and medical aid insurance to cover any of its employees who are members of the Washington law enforcement officers' and fire fighters' retirement system, and/or retired former employees . . . through contracts with regularly constituted insurance carriers, with health maintenance organizations . . . or with health care service contractors. . . ."

The majority of employers have joined with their respective associations to provide medical plans for their employees, including law enforcement officers and fire fighters. The state County Commissioners have established the Washington Counties Insurance Fund which includes health care coverage. The Association of Washington Cities also have a fund - the Association of Washington Cities Employees Benefit Trust - which provides indemnity coverage as well as HMO coverage. The Washington Fire Commissioners Association provide a plan with options for indemnity or HMO coverage.

Those political subdivisions not opting to utilize their association plans may independently obtain health care coverage through various sources. Some chose union health and welfare plans (e.g., Teamsters), or other individual insurance providers. A number of the larger political subdivisions have opted for the self-insurance route as shown in Table 4.

Table 4
Health and Welfare Self-Insured LEOFF 1 Employers
(Source: Risk Management, Department of General Administration)

Counties
King
Skagit
Spokane
Whatcom
Cities
Anacortes
Bellevue
Bellingham
Bothell
Edmonds
Everett
Kennewick
Kent
Mount Vernon
Mukilteo
Pasco
Redmond
Renton
Richland
Seattle
Spokane
Tacoma
Tukwila
Wenatchee
Yakima
Washington Fire Commissioners

Medical Information

LEOFF 1 retirement questions regarding general information are easily answered because data are centrally maintained. The costs to the employers are reflected in the contribution records maintained by the Department of Retirement Systems (DRS). Statistical data are available from the Office of the State Actuary (OSA).

Questions regarding the LEOFF 1 medical benefit, its costs, etc., are not readily available because no such centralization exists. Information regarding these benefits and their administration was deemed necessary for the actuarial study required by the Legislative mandate. In order to obtain this information it was necessary to go directly to employers through a survey.

Employers Surveyed

There are 38 counties, 154 cities, 54 fire districts and 5 port districts that either currently employ LEOFF 1 employees or are the employer of record for retired LEOFF 1 members. A representative sample of various employers was sent a survey questionnaire. This questionnaire sought to obtain the necessary data for the actuarial study. In determining which employers were to receive the survey, the Washington Association of Counties asked that a substantial number of their members be included. Beyond that, an effort was made to sample a diverse group taking into consideration the number of LEOFF 1 members connected to the employer, the geographic location and whether or not they were insured under an association health plan. Those selected are reflected in Table 5. Among these employers are 21 counties, 43 cities and 26 fire districts. This mix of employers differed somewhat from the mix of employers in the 1995 survey which included 24 counties, 49 cities, 21 fire districts and 5 port districts.

Table 5
Surveyed LEOFF 1 Employers

Counties			
Members of Association Health Care		**Health Care Provided by Other Means**	
Benton		Chelan	Pend Orielle
Grays Harbor		Clallam	Pierce
Kittitas		Clark	Skagit
Lewis		Douglas	Snohomish
Pacific		Grant	Thurston
		King	Wahkiakum
		Kitsap	Whatcom
		Okanogan	Yakima
Cities			
Aberdeen	Issaquah	Bellevue	Pasco
Bremerton	Lacey	Benton City	Pullman
Chehalis	Marysville	Brewster	Redmond
Chelan	Mill Creek	Castle Rock	Renton
Cheney	Moses Lake	Coupeville	Richland
Clarkston	Othello	Ellensburg	Seattle
Colville	Port Townsend	Everett	Spokane
Dayton	SeaTac	Kennewick	Tacoma
East	Snoqualmie	Monroe	Vancouver
Ephrata	Sunnyside	Olympia	Yakima
Fircrest	Toppenish		
Goldendale			

Fire Protection Districts			
Chelan 01	Lacey 03	Clark 03	Pierce 07
Clark 05	Lewis 12	Grant 03	Spokane 01
Clark 06	Mason 02	King 24	Whatcom 13
Cowlitz 02	Pierce 05	Pierce 02	
Douglas 02	Pierce 21		
King 02	Snohomish 11		
King 10	Spokane 09		
King 16	Thurston 03		
Kitsap 07	Yakima 05		
Kittitas 02			

Survey Instruments

The survey instruments used in this survey were essentially identical to the ones used in the 1995 survey. Three versions were used depending on the type of employer. The first version addressed those employers who were members of their respective association health care plan. The second version addressed the remaining LEOFF 1 employers. The third version addressed the three employer association health care plans themselves. (See Appendix C for the actual forms.)

The questionnaires contained common questions in each version. These questions addressed the following:

- ***Employer Profile:*** This segment called for employee, retiree, salary and budget information. This information was requested, not for actuarial purposes, but for use in placing medical costs in context. The actual demographic information used in the actuarial valuation was derived from 1999 data for that year's actuarial valuation.

- ***Medicare Coverage:*** Questions were asked to learn the extent to which LEOFF 1 retirees are being covered under Medicare.

- ***Nursing Home/Long Term Care:*** The questions were aimed at learning whether the LEOFF 1 nursing home medical benefits were covered by present insurance, and the current extent and level of long term care among LEOFF 1 retirees.

- ***Direct Cost for Medical Benefits:*** Not all medical costs are covered by insurance. Under these questions, the survey attempted to learn the amount of non-insured costs experienced by the employer. In addition, the employer was asked from what source direct payments are paid (i.e., departmental funds of the sheriff or police or the current expense of the political subdivision.

- ***Pre-Funding and Measurement of Retiree Medical Benefits Obligations:*** These questions sought to find which of the employers had previous actuarial valuations of their own liabilities, the main results of this valuation, and how they addressed the liabilities. It also sought to find which of the First Class Cities had utilized revenues available to them because of their pre-LEOFF retirement systems.

Additional questions were used for those LEOFF 1 employers who do not participate in their association health care plans and the association plans themselves:

- ***Provision of Medical Benefits:*** Questions were asked to determine if the employer self-funded the insurance coverage or if they paid premiums to another health care plan. In each instance, the amount of deductibles, co-insurance, maximum out-of-pocket expenses, and Medicare coordination were requested. The questions also addressed premium rates and the degree of similarity of rates between LEOFF 1 active members and retirees and other employees.

- ***Budgeting and Reporting:*** These questions called for information about the availability of separate financial reporting and claims experience.

- ***LEOFF 1 Claims Breakdown:*** This segment asked for claims information for each of the years 1996, 1997 and 1998.

The questionnaires submitted to the selected employers had a letter attached from their respective association. The letter stressed the cooperation of the associations in the survey, the importance of the data, and urged the employer to answer and return the questionnaire. Follow up calls were also made by both the county and city associations.

Survey Results

Survey Response:

Of the 90 surveys sent out, 69 employers responded. Table 6 provides a breakout of this response and compares it to the 1995 survey.

Table 6
Employer Response to Survey

Political Subdivision	Distributed	Responded	Percent Response in 2000	Percent Response in 1995
Counties	21	16	76%	79%
Cities	43	39	91%	71%
Fire Protection Districts	26	14	54%	62%
Port Districts	____	____	____	60%
Total	90	69	77%	71%

The quantitative results of the survey are shown in Appendix D. The non-quantifiable responses, especially related to the claims data, will be dealt with later in this discussion.

Medicare Coverage:

Medicare is a federally subsidized program which provides health care for eligible persons who have attained age 65. It consists of two parts: Part A (Hospital Insurance) provides limited inpatient hospital services, skilled nursing facilities, home health services and hospice care. Part B (Medical Insurance) helps pay for the cost of physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies.

Generally, to receive Medicare Part A without paying premiums one must:

1. Attain age 65;
2. Already be receiving or be eligible to receive Social Security or Railroad Retirement benefits;
3. One's spouse is eligible to receive Social Security or Railroad Retirement benefits.
4. There is also special eligibility for those who are under age 65 but meet criteria for disability or certain kidney problems.

If a person is age 65, but does not meet the other requirements of Part A, coverage is possible through payment of a monthly Part A premium that is currently $301. This premium is generally revised annually.

To obtain Medicare Part B one must be receiving Part A and paying a monthly premium. This premium is currently $45.50 and is generally revised annually.

The importance of Medicare is reflected in the practice known as "coordination of benefits." Most, if not all, insurers or employers require that a person qualified for Medicare first submit the claim to Medicare for payment and the insurer or employer will pay the remainder of the claim. This procedure, of course, reduces the overall claims payment for eligible persons 65 or older.

The employers were asked three questions regarding Medicare. Table 7 reflects the responses.

Table 7
Utilization of Medicare

	Yes	No	No Response/Unknown	Total
Are your LEOFF 1 retirees over age 65 eligible for Medicare?	55%	13%	32%	100%
Are eligible LEOFF 1 claims submitted to Medicare for payment before applying insurance coverage?	41%	21%	38%	100%
Do you pay Medicare Part B premiums on behalf of or reimburse LEOFF 1 retirees?	32%	36%	32%	100%

Table 8 shows the distribution of responding employers according to the percentage of LEOFF 1 members known to be eligible for Medicare.

Table 8
Medicare Coverage of Eligible LEOFF 1 Members

Retirees Eligible for Medicare	Employer Distribution
Under 20%	4%
20% - 29%	11%
30% - 39%	7%
40% - 49%	2%
50% - 59%	15%
60% - 69%	----
70% - 79%	4%
80% - 89%	4%
90% - 99%	----
100%	53%
Total	100%

Actuarial Valuation

The actuarial consulting firm of Milliman & Robertson, Inc., as in 1995, was selected from a number of firms responding to a Request for Proposal issued by the Office of the State Actuary. The primary thrust of the contract was to provide an estimate of the future liabilities of LEOFF 1 retiree medical benefits. Obviously, complete data are not available for all employers, thus the consultant utilized data from a sample population.

From this data, the consultant developed assumptions which were applicable to this state's LEOFF 1 population. Using these and other appropriate assumptions, a valuation of the LEOFF medical liabilities was performed. The results were then allocated to the LEOFF 1 employers. The valuation in its entirety may be found in Appendix E.

The valuation applies only to LEOFF 1 statewide. The consultant did not focus on variations in experience, prior funding, Medicare coordination, etc., of individual LEOFF 1 employers. The valuation results by employer provide useful information about the magnitude of local liabilities, but the individual employer should look to a valuation which considers local practices. In other words, this valuation does not satisfy the requirements of financial disclosure. It simply provides an awareness of approximate liability and a basis for future fiscal planning to meet such liability.

Costs of the Medical Services Benefit

Valuation Standards:

The valuation results were produced in accordance with the Statement of Financial Accounting Standard No. 106 (SFAS 106), issued by the Financial Accounting Standards Board (FASB). This board sets the standards for private sector accounting and financial statements, including non-pension post-retirement benefits. FASB has a public sector counterpart known as the Governmental Accounting Standards Board (GASB). GASB, however, does not presently require public entities to disclose non-pension post-retirement benefits. Therefore, the private sector standards of SFAS 106 were applied to this LEOFF 1 study.

SFAS 106 maintains that the cost of non-pension post-retirement benefits should be developed over the working life of the employee - that is, from the date of hire to the date the employee is first eligible for the benefit. The importance of this standard is not that the employer actually pays the resulting liability; rather, the importance lies in the degree of commitment acknowledged by the employer and the fact that others are informed of this commitment.

EPBO and APBO:

FASB recommends two measures of liabilities: Expected Post-Retirement Benefit Obligation (EPBO) and Accumulated Post-Retirement Benefit Obligation (APBO). The liability EPBO, as of the date of the valuation, is the actuarial present value[1] of the expected medical benefit from the date of retirement until death. This liability (or obligation) accrues during the working lives of the respective membership and it

[1] *The actuarial present value is the value of a future sum of dollars multiplied by the probability of specified events occurring, discounted by one or more specified rates. In this instance the main events are the need for medical and long term care. The factors are the assumptions which are discussed later in this chapter.*

represents the total liability of the employer(s). The APBO, on the other hand, represents how much of the EPBO has been "earned" from the date of hire to the date of the valuation.[2] Tables 9 and 10 show the EPBO and the APBO determined in the valuation.

Table 9
Comparison of LEOFF 1 EPBO Valuation Results: 1995 and 2000
Assumes Employees Age 65 or Older Pay Medicare Part B Premium
(Source: Valuations as of 1/1/1994 and 6/14/2000; Milliman and Robertson, Inc.)

	1995 EPBO *(In Millions)*			2000 EPBO (In Millions)		
	Medical	Long-Term Care	Total	Medical	Long-Term Care	Total
Current Retirees	$304	$ 99	$403	$437	$109	$546
Actives Eligible to Retire with Full Benefits	62	15	77	75	14	89
Actives Not Eligible to Retire with Full Benefits	161	31	192	62	11	73
Total All Participants	$527	$145	$672	$574	$134	$708

Table 10
Comparison of LEOFF 1 EPBO Valuation Results: 1995 and 2000
Assumes Employees Age 65 or Older Pay Medicare Part B Premium
(Source: Valuations as of 1/1/1994 and 6/14/2000; Milliman and Robertson, Inc.)

	1995 APBO *(In Millions)*			2000 APBO *(In Millions)*		
	Medical	Long-Term Care	Total	Medical	Long-Term Care	Total
Current Retirees	$ 304	$ 99	$403	$ 437	$ 109	$ 546
Actives Eligible to Retire with Full Benefits	62	15	77	75	14	89
Actives Not Eligible to Retire with Full Benefits	132	26	158	55	10	65
Total All Participants	$ 498	$ 140	$ 638	$ 567	$ 133	$ 700

[2] *It is important to note that in this valuation the EPBO and the APBO are essentially the same. This is due to the fact that LEOFF 1 is a closed system (i.e., no new membership) and the vast majority of the membership is very near the age of first being eligible to retire. Thus, the earned benefit to date and the total earned benefit are very close to one another.*

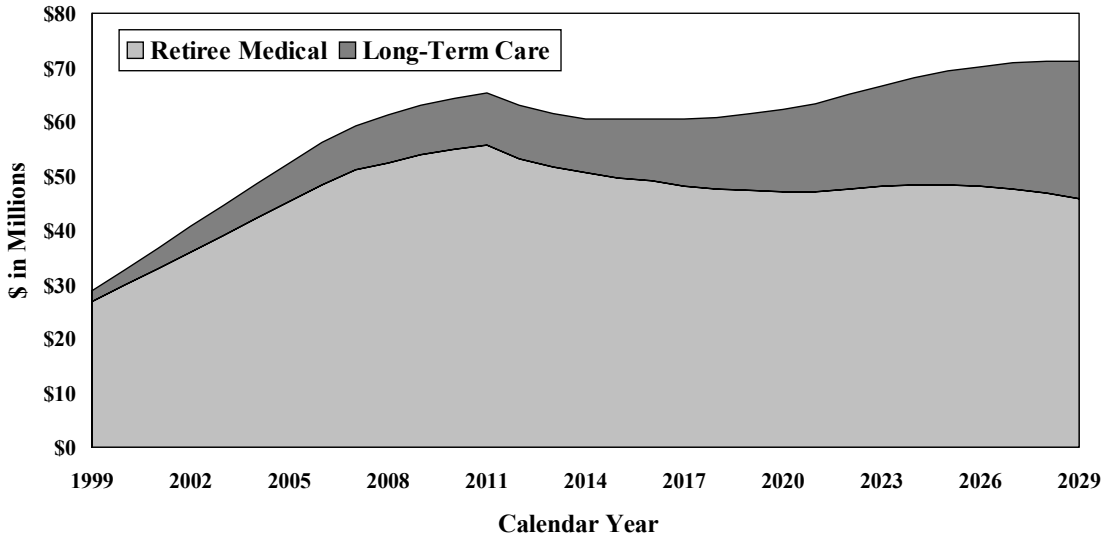
Funding:

SFAS 106 provides a useful standard whereby the value of post-retirement benefits may be measured and used in comparing one entity to another. For most employers, the APBO is the most commonly used standard as it provides the liability accrued to-date. Also, for those employers so desiring, the APBO provides them with a basis upon which they may prefund these medical benefits. Although in the case of LEOFF 1, as the EPBO and APBO are essentially the same, this report will generally utilize the EPBO.

If prefunding had been used from 1970 (the initial date of LEOFF 1), this approach may have made sense, especially for large employers. In a system where membership is growing, prefunding levels the cost over time and is valuable for budgeting purposes. Prefunding, however, for LEOFF 1 employers at this time would not be fiscally prudent as the LEOFF 1 membership is rapidly declining to zero.

Most LEOFF 1 employers are currently funding medical benefits on a pay-as-you-go basis. To indicate the overall impact of this, Figure 3 shows the statewide projected cash flow for the next 30 years. The figure shows that medical care dominates the cash flow but that the cost of long term care will be increasing over time.

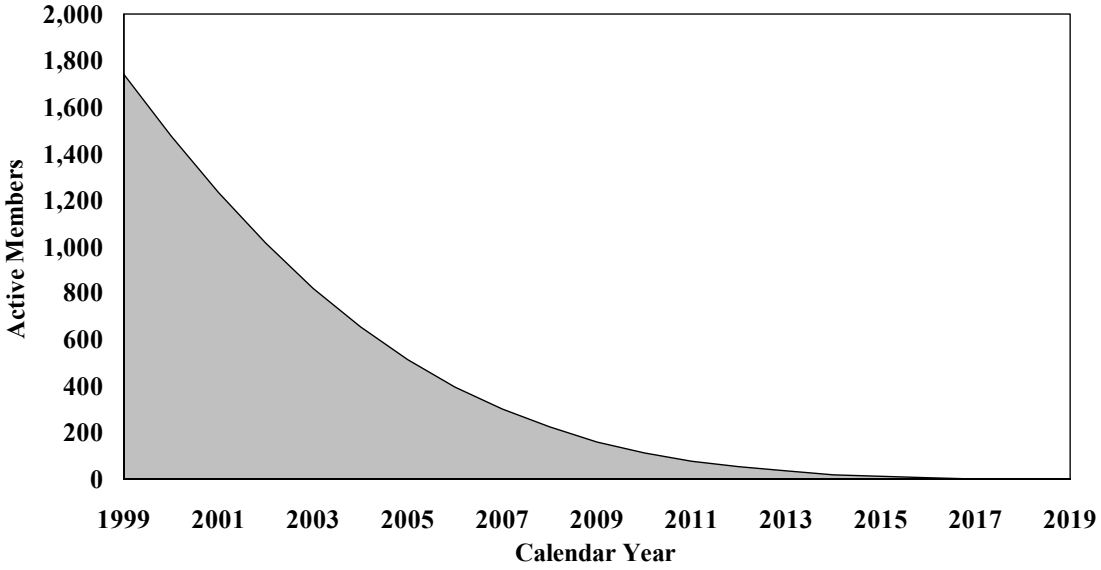
Figure 3
LEOFF 1 30 Year Cash Flow Projection
Assumes all members are covered by Medicare
(Source: Actuarial Valuation, June 14, 2000; Milliman & Robertson, Inc)



Assumptions

The key elements of any actuarial valuation are the assumptions used. The first set of assumptions are demographic (e.g., gender, disability, mortality). For this valuation, as in 1995, the demographic assumptions used in the medical valuation are the same as those used in the recent valuation of the LEOFF retirement system. The LEOFF 1 membership, as of December 31, 1999, is used as the basis of all calculations. As already indicated, LEOFF 1 is closed to new membership, so this population is finite as shown in Figure 4.

Figure 4
Projected LEOFF 1 Active Membership



The second set of assumptions are economic. Three are used in the valuation and they are the same as used in 1995:

- Discount rate of 7.5 percent to reflect the general investment return rate.
- Medical trend rate of 6.5 percent to reflect annual increase in the cost of future medical services.
- Long term care trend rate of 5.5 percent to reflect annual increase in the future cost of either long term institutional or in-home care.

Claim Cost:

Another key assumption is the expected monthly claim cost per person. Table 11 reflects such claim costs used in the valuation.

Table 11
Monthly Claim Costs

Age	Claims Cost per Person
52	$ 296
57	422
62	585
67	201

Claims cost generally increases with age until the individual attains age 65 when Medicare eligibility is assumed. The costs in the table were developed using actual premiums or experience from a sample of LEOFF 1 employers combined with broader information from other health care plans. These costs are then projected to the future by the medical trend rate. Current individual employers may be actually experiencing higher or lower costs.

Long Term Care Costs:

As in 1995, the development of cash flow and liability estimates for long term care depend heavily on three assumptions:

- The probability at each age that a retiree begins receiving the long term care benefit.
- The average duration of the benefit.
- The average cost per month of the benefit provided.

Assumptions for each of these factors were developed from insurance industry long term care experience, modified to reflect the limited LEOFF 1 experience. Table 12 reflects the probability of commencing long-term care benefits; and Table 13 reflects the length of stay in months. Institutional care consists of skilled care (medical care under order of a physician, provided on 24-hour basis); intermediate care (continuous care but not meeting the medical requirements); and custodial care (assistance in carrying out the activities of daily living). Non-institutional care includes all home health and adult day-care facilities.

Table 12
Probability of Commencing Long-Term Care Benefits

Age	Institutional Care	Non-Institutional Care
45	0.000951	0.002690
55	0.001207	0.006130
62	0.002033	0.011130
67	0.003221	0.018300
72	0.009598	0.030590
77	0.023631	0.045710
82	0.042422	0.073800
87	0.075462	0.109250
92	0.134381	0.108630
97	0.227038	0.108630

Table 13
Average Length of Stay (In Months)

Age	Institutional Care	Non-Institutional Care
45	23	18
55	22	19
62	21	16
67	19	15
72	16	12
77	15	11
82	14	11
87	14	11
92	13	10
97	10	10

The assumed average monthly costs are as follows:

Nursing Facilities	$4,220
Assisted Living Facility	$3,376
Home Care	$1,540

Three comments regarding the trend rate of long term care assumptions are in order as they may appear low compared to a similar trend in a general commercial product trend rate. First, generally speaking, an employer's long term care plan will experience utilization different than that of a plan purchased by an individual. When an individual purchases a plan, he or she has committed or made an explicit decision to use long

term care if the need arises. Further, the individual is giving tacit approval for family members to commit the individual to such care if the future need arises. With the employer plan, on the other hand, the individual or family has not gone through this process to reach the same degree of commitment.

Second, the sole foundation of the LEOFF 1 medical benefit is medical necessity. This is a narrower standard than used in most individual insurance contracts. Benefits under these contracts are available when the person is no longer able to perform certain "activities of daily living" (ADL). ADLs are of two types: basic and instrumental. Basic ADL's are dressing, eating, ambulating, toileting, and hygiene. Instrumental ADL's are shopping, housework, accounting, food preparation, and transporting. Most insurance products use both medical necessity and ADL.

Finally, the claims experience of long term care under LEOFF 1 appears to be significantly lower than expected when compared to insurance company experience. Whether this is due to the factors just discussed or other factors is uncertain. If, however, the insurance industry experience was relied on more heavily the EPBO for long term care benefits would have been 50 percent higher.

Trend Rate Sensitivity:

The consultant was asked to determine the sensitivity of trend rates. That is, what is the variation if the trend rate were one percent higher or one percent lower. Table 14 shows the results.

Table 14
Sensitivity of Trend Rates
($ in Millions)

	Valuation Trend Rates	Valuation Trend Rates Plus 1%	Percentage Increase	Valuation Trend Rates Minus 1%	Percentage Decrease
Medical APBO	$ 567	$ 637	12%	$ 508	(10%)
Long Term Care APBO	133	162	22%	109	(18%)

Medicare

In a discussion of retiree medical costs, Medicare must be taken into consideration. This is no less true regarding LEOFF 1 retirees. Eligibility for Medicare is normally gained through contributions deducted from compensation at the same time the contribution to Social Security is made. Some LEOFF members, however, may not be required to make either Social Security or Medicare contributions as employees of police or fire departments. Such LEOFF members may still become eligible in one of three ways:

1. Secondary employment of the member or retiree;
2. On the basis of their spouse's eligibility; or
3. The member or employer paying a post-retirement Medicare Part A premium.

Also, as discussed earlier, generally upon attaining age 65, Medicare Part A provides the eligible recipient with limited hospitalization and skilled nursing care. Part B coverage provides for non-hospital medical care and services. The Part B coverage requires payment of a monthly premium.

The EPBO and APBO reflected previously in Table 9 are statewide liabilities and do not indicate the potential impact on the individual employer. The EPBO, APBO and the accrual of service cost for the annual benefit earned has been allocated to each employer. This allocation was made on the basis of retirees age 65 or older being eligible for Medicare and retirees age 65 or older paying the Medicare Part B premium. Appendix F shows the impact of the employer paying the Part B premium and the impact of no Medicare coverage for those age 65 or older.

Analysis

This section will focus on four areas: employer liability, funding, disability boards and Medicare. This analysis is intended to provide background information for the Legislature and LEOFF 1 employers.

Employer Liability

The Expected Post-Retirement Benefit Obligation (EPBO) for medical and long term care is projected to be $708 million plus the cost of any employer paid Medicare Part B premiums. On a per capita basis, the EPBO is over $81,000 per LEOFF 1 member.

It is helpful to put the medical benefits EPBO in perspective with the LEOFF 1 retirement benefits liabilities. This is reflected in Table 15. The medical benefits EPBO is presented in two ways. One is consistent with the employee paying the Medicare Part B premium and the other is the employer paying the Part B premium. The EPBO is both the unfunded liability and the total liability since we assume there is little prefunding of medical benefits. The post-retirement medical liability is almost 20% of the size of the total pension liability and the unfunded liability of the medical benefit is almost as large as the surplus in the pension fund.

Table 15
LEOFF 1 Retiree Health Care Liabilities and
LEOFF 1 1999 Retirement Valuation Results
(Source: Milliman and Robertson, Inc. and Office of the State Actuary)

	($ in Millions) EPBO		
	Medical	**Long-term Care**	**Total**
	(Employee Pays Medicare Part B Premium)		
Pre-Age 65 Benefits	$ 293	$ 8	$ 301
Age 65 or Older Benefits	281	126	407
Total All Ages	$ 574	$ 134	$ 708
	(Employer Pays Medicare Part B Premium)		
Pre-Age 65 Benefits	$ 293	$ 8	$ 301
Age 65 or Older Benefits	343	154	497
Total All Ages	$ 636	$ 162	$ 798
LEOFF 1 Retirement System Total Pension Liability			$4,262
LEOFF 1 Retirement System Surplus of assets over earned benefits			$ 1,014

The future impact may be viewed in terms of salaries paid. Figure 5 shows the projected annual LEOFF 1 salaries and the projected annual cash flows for medical and long term care. As can be seen, the medical and long term care costs increase while the salaries decrease.

Figure 5
LEOFF 1 Projected Salaries and Projected
Total Medical Benefits Cash Flow
(Source: Milliman & Robertson, Inc.; Office of the State Actuary)

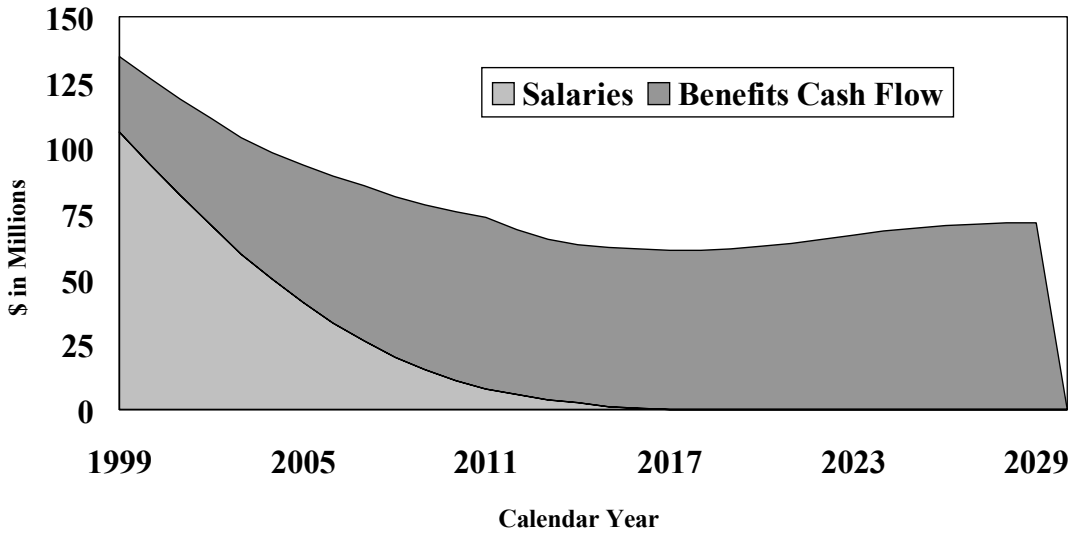


Figure 6 shows the projected salaries of both LEOFF 1 and 2 as well as the medical and long term care projected cash flows.

Figure 6
LEOFF 1 and 2 Projected Salaries
and Total Medical Benefits Cash Flow
(Source: Office of the State Actuary; Milliman & Robertson, Inc.)

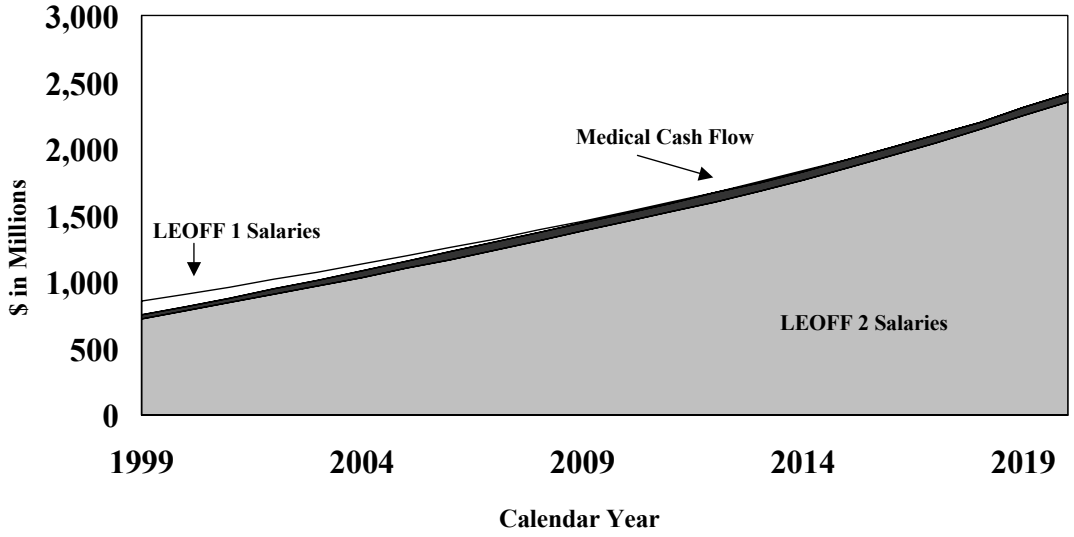


Figure 7 provides another view of costs. It shows the cost of medical benefits as a percent of compensation as is used in the state's retirement systems. Presently, payments for medical services equal 3.5 percent of combined LEOFF 1 and 2 salaries. This amount will rise, reaching a plateau of 4.5 percent to 4.7 percent, then begin its descent.

Figure 7
LEOFF 1 Medical Services Cash Flow
As a Percentage of LEOFF 1 and 2 Compensation
(Assumes the Employee Pays Medicare Part B Premium)

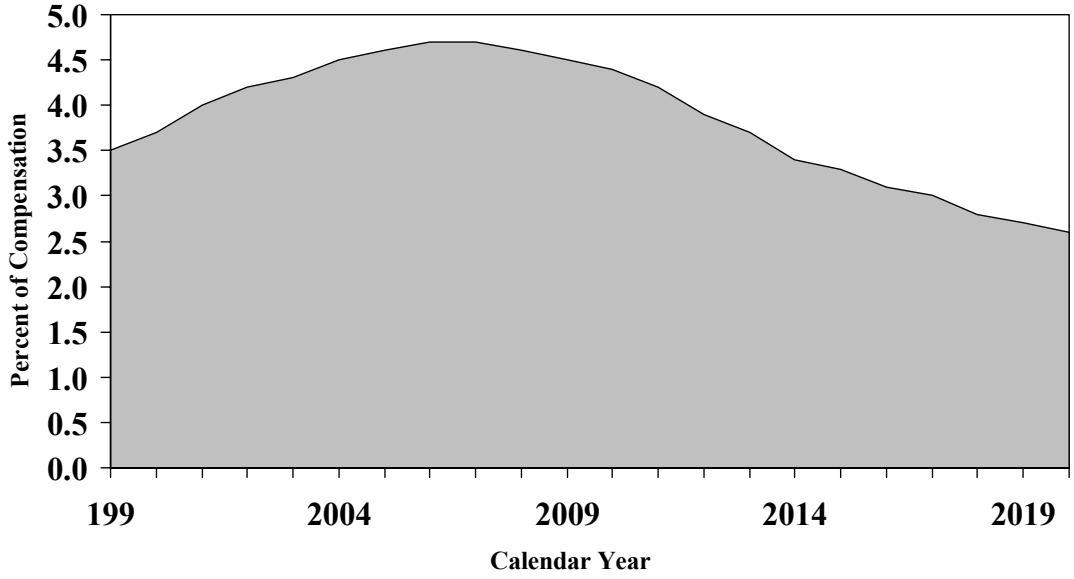
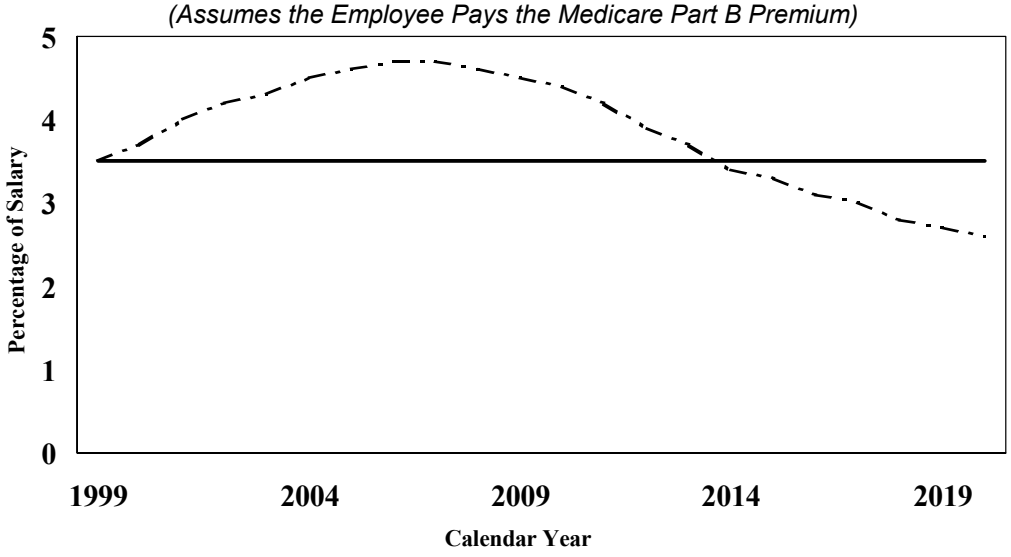


Figure 8 compares the projected cash flow for the medical benefits (which is a pay-as-you-go approach) to a level percentage of salary. The graph reflects an annual payment of 3.5 percent of the total LEOFF salaries over a period of 21 years towards the payment of the medical liability.

Figure 8
Cash Flow of Medical Benefits as a Percent of Total LEOFF Salaries Compared to a Level Percentage of Compensation
(Assumes the Employee Pays the Medicare Part B Premium)



Funding

Funding medical is generally better understood than the funding of pension benefits. Medical benefits are generally not pre-funded as are pension benefits. Employers usually utilize insurance contracts to both assist in administration and lower the risk of high claims in any one year. This creates a more predictable cost for providing medical benefits.

All employees are usually covered by a group contract for medical insurance. There is generally no individual selection or underwriting by the insurance contract where some members are covered and some are rejected. This process for providing medical benefits to either employees or retirees is one that is well developed by the insurance industry and utilized by almost every employer. These costs may increase more rapidly than anticipated but are unlikely to fluctuate up or down wildly from year to year.

The situation with long term care is substantially different. The chance of any individual having a long term care claim is relatively small. On the other hand, the cost of any one claim is usually quite high. This means the risk for any employer of claims being very low or very high from year to year is substantial. The usual process for dealing with this situation would be to pool the risk through an insurance contract. This avenue is generally unavailable at this time.

Policies for long term care tend to be individual policies. That is each individual is sold a policy based on their age and health. Some are uninsurable. The policies tend to provide a specific set of benefits that address the overall need for long term care. This benefit is broader than that required by LEOFF. The LEOFF requirement is "medical necessity." This is not the same standard as used in the insurance industry. It is not clear exactly how the two differ, but it is clear they do. The result is that almost all employers are using insurance where necessary to share the risk of medical benefits. Very few LEOFF 1 employers are protected from the risk of long term care.

The cost of long term care will certainly increase each year. Long term care inflation, like medical inflation, has increased faster than the overall CPI. Another reason the cost will increase is the aging of the covered group. LEOFF 1 retirees are currently a very young group for retirees. As they age there will be greater utilization of this benefit.

Risk:

Risk for the purpose of this discussion is a deviation from expected expenses or an experience of unanticipated expenses.

This study reflects little current utilization of long term care. Because there is so little experience, a statistical procedure was used applying probabilities to demonstrate how the incidence of long term care is likely to change over the next fifteen years. This procedure provides an expectation of long term care admissions given a specified population. The hypothetical sample represent an employer with 65 retirees and some actives in 1999 and projects the incidence of long term care admissions in 2000, 2005, 2010 and 2015. The result is reflected in Tables 16 and 17.

Table 16
Expectation of Institutional Long Term Care Admissions
(Skilled Nursing, Intermediate Care and Custodial Facilities)

Retirees	- - - - - - - - Probability of Claims Distribution - - - - - - -				
Admitted	**1999**	**2000**	**2005**	**2010**	**2015**
None	72%	69%	70%	53%	25%
1	26%	27%	26%	34%	41%
2	2%	4%	4%	11%	23%
3				2%	7%
4					4%
5					
Total	100%	100%	100%	100%	100%

1994: Sample size 65
1995: Sample size 66
2005: Sample size 70
2010 Sample size 72
2015: Sample size 57

Table 17
Expectation of Non-Institutional Long Term Care Admissions
(Home Health and Adult Day-Care Services)

Retirees	- - - - - - - - Probability of Claims Distribution - - - - - - -				
Admitted	**1999**	**2000**	**2005**	**2010**	**2015**
None	51%	49%	45%	27%	16%
1	33%	37%	38%	40%	35%
2	14%	12%	12%	23%	25%
3	2%	2%	5%	8%	15%
4				2%	8%
5					1%
Total	100%	100%	100%	100%	100%

1994: Sample size 65
1995: Sample size 66
2005: Sample size 70
2010 Sample size 72
2015: Sample size 57

The table validates what one intuitively believes - long term care admissions of any type will increase over time as the population ages. With a retiree population of 65 or so retirees the highest probability is there will be no claims. However, some will have claims and the cost of those claims may be quite high. Employers covering fewer retirees are less likely to have a claim but are more likely to be hurt if there is one. The largest of employers should have more predictable claims.

The other aspect of long term care is length of stay. The consulting actuary provided average length of stay for both nursing home and non-nursing home situations. These are shown in Table 18.

Table 18
Average Length of Stay in Months
(Source: Milliman & Robertson, Inc.)

Age	Institutional Care	Non-institutional Care (Home & Adult Care)
45	23	18
55	22	19
62	21	16
67	19	15
72	16	12
77	15	11
82	14	11
87	14	11
92	13	10
97	10	10

Based on survey results, an informal survey of local costs, and other research information, the consulting actuary provided the following average costs:

Nursing facility:	$4,220 per month
Assisted living facility:	$3,376 per month
Home Care:	$1,540 per month

These rates are not offset by Medicare payment or other insurance coverage.

Fire Districts:

Although all employers are concerned with their capacity to meet unexpected or catastrophic events, a particular risk is faced by Fire Protection Districts. Except for two which receive a portion of a distribution from the fire insurance premium tax, fire district revenues are restricted to property tax levies and assessing benefit charges.

The State Constitution provides that the total property tax levied may be 1 percent of the true and fair value of the property. Specific political subdivisions are authorized to levy property tax. Among them are taxing districts. These districts are divided into senior taxing districts (cities and counties) and junior taxing districts (e.g., fire protection, library, hospital and metropolitan parks).

Per $1,000 of assessed valuation, the statutes authorize:

- Cities to levy up to $3.375
- Counties to levy up to $1.80
- County road districts to levy up to $2.25; and
- Library, hospital and metropolitan parks to levy $0.50 each.

Fire districts have a different levy authority. Per $1,000 of assessed value, they may levy the following:

- $0.50 as long as the levy lid is not exceeded; plus
- An additional $0.50 as long as the levy lid is not exceeded; plus
- Amounts in excess of the two $0.50's above, if approved in a special election and does not exceed the levy lid; plus
- $0.50 as long as the levy lid is not exceeded and the district employs at least one full time employee.

In the aggregate, the total property tax levied by senior and junior taxing districts may not exceed $5.90 per $1,000 of assessed valuation. Senior taxing districts are given priority of the distribution of this $5.90.

Assume a fire protection district situated in an unincorporated county area. The district is authorized to levy $1.50 per $1,000 of assessed valuation (the two $0.50 levies and the $0.50 levy because of a full time employee). There is also a library district within the fire protection district. Table 19 shows the distribution of the allowable property tax.

Table 19
Property Tax Example #1

Political Subdivision	Taxing Authority	Property Tax Levied	Unlevied Difference
County - General	$ 1.80	$ 1.80	
County - Road	2.25	2.25	
Fire District	1.50	1.35	$ 0.15
Library District	0.50	0.50	
Total	$ 6.05	$ 5.90	$ 0.15

Assume now the same situation except a hospital district is authorized. Table 20 reflects this situation.

Table 20
Property Tax Example #2

Political Subdivision	Taxing Authority	Property Tax Levied	Unlevied Difference
County - General	$ 1.80	$ 1.80	
County - Road	2.25	2.25	
Fire District	1.50	0.85	$ 0.65
Library District	0.50	0.50	
Hospital District	0.50	0.50	
Total	$ 6.55	$ 5.90	$ 0.65

The additional districts reduce the revenue of the fire district otherwise available for operations. Obviously, districts facing this situation are at risk if they incur unforeseen, ongoing expenditures.

The law provides an additional source of revenue for fire districts. They may apply a benefit charge on personal property and improvements to real property within the fire district. This charge is required to be (a) reasonable and (b) based on measurable benefit provided by services of the district to such property. The charge, however, may not exceed 60 percent of the operating budget of the fire district.

In order to apply the charge, the district must receive approval from the voters of the district. If approved by 60 percent of the voters in a general or special election, the district may apply the charges up to six years. Upon completion of the six years they must go back to the voters.

Funding Options:

Most of the medical costs for post-retirement medical can be insured through generally available insurance products. This process does not reduce the overall cost of paying the benefits but does make the cost to each employer more predictable and budgetable.

Long term care costs are more difficult to deal with. Large employers may have somewhat predictable costs and could offset rising costs by pre-funding. Smaller employers are unlikely to have a predictable pattern of claims. To mitigate the risk of unanticipated large claims, employers could take one of several actions:

1. Set aside some money each year (pre-fund) to offset claims when and if they occur.

   This process will help if claims occur after some period of savings and funds have been built up to a level sufficient to offset claims. It may be difficult for a small employer to set aside enough to make a difference.

2. Buy commercial insurance product to offset some of the costs.

   Buying long term care insurance is a form of pre-funding. Continuing to pay the premiums will significantly reduce the risk to the employer for those that are covered. Insurance products are available on an individual policy basis. Most employers could not insure all of their retirees because they could not pass the underwriting standards. Employers are left with those in poor health or advanced age that are most likely to have a claim. Insurance products are written for a broader individual market that has a different definition of need for long term care. These benefits and premiums may not be appropriate for this purpose. Insurance products are often priced conservatively with significant expense loadings. Premium costs may greatly exceed benefits.

3. Join together in a risk pool to eliminate claim fluctuations on an individual employer.

   A risk pool shares the claim costs of the group with all employers in the pool. There is usually little pre-funding so that overall claims will increase as the cost of the benefit increases and the utilization increases as the group ages.
   The benefit can be targeted to the LEOFF 1 requirement exactly as in the statute and payable only when the local disability board makes the determination.

   Catastrophic Medical Benefits: A risk pool could be designed to also protect those LEOFF 1 employers who are faced with an exceptional, uninsured medical liability but had insufficient funds to meet it. This type of claim would be one that is covered by the LEOFF 1 plan but is not covered by most medical insurance plans. It could be a type of benefit required or total benefits that exceed maximum insurance policy limits. Clearly, coverage like this would have to be carefully crafted.

Disability Boards

There are 80 disability boards throughout the State. Of these, 41 are administered within individual cities while the remaining 39 are mandated for each county administering to the county and other political subdivisions not having their own disability board. The function of these boards is two-fold:

- Determine and approve LEOFF 1 disability leave and disability retirement.
- Determine eligible LEOFF 1 medical benefits.

The First Class City boards have one additional function. They have statutory responsibilities for the administration of the pre-LEOFF retirement systems for police and fire fighters.

Determination of Disability Leave and Disability Retirement:

The disability board's main function is the determination of disability, either duty or non-duty.[3] Generally, when a disability is initially determined by the board, a leave period of up to six months is granted, unless waived by the member. At the end of the disability leave period, disability retirement, again either duty or non-duty, may be granted by the board. In prior years, there were greater numbers of LEOFF 1 members seeking disability leave and retirement and board members were more engaged in this process. Circumstances, however, have changed and the workload of the boards has shifted away from disability determinations.

Figure 9 reflects the retirement age of the members granted disability retirement through December 31, 1999, and Figure 10 reflects the years of service for these members at retirement.

[3] *Of the 4,215 LEOFF 1 members in disability retirement status as of December 31, 1999, only 640 (15 percent) of them are in non-duty status.*

Figure 9
Age of Retirement of LEOFF 1 Disabled Members

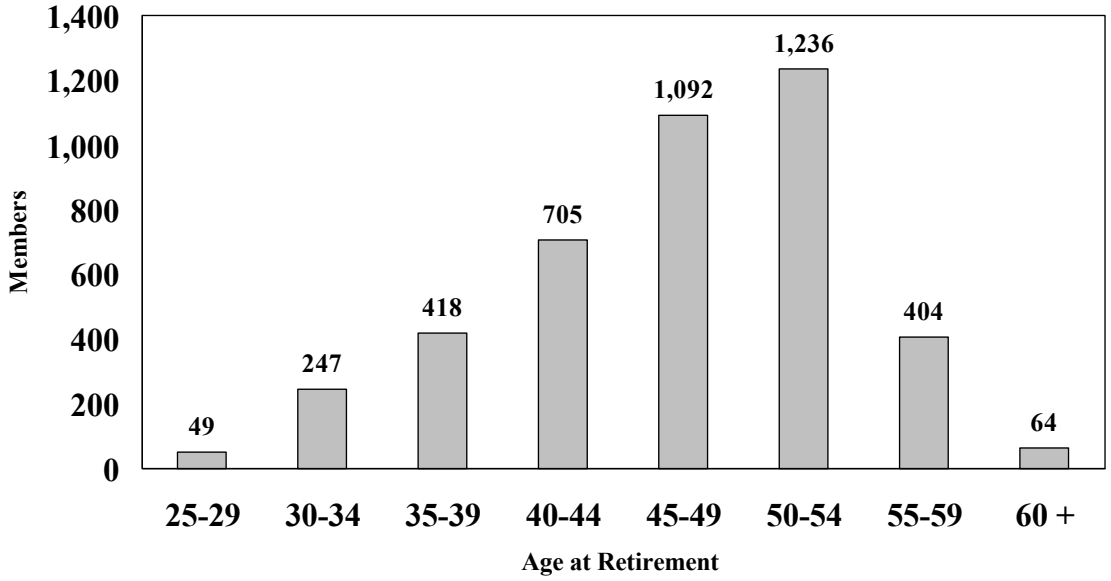


Figure 10
LEOFF 1 Disability Retirees' Years of Service
(As of December 31, 1999)

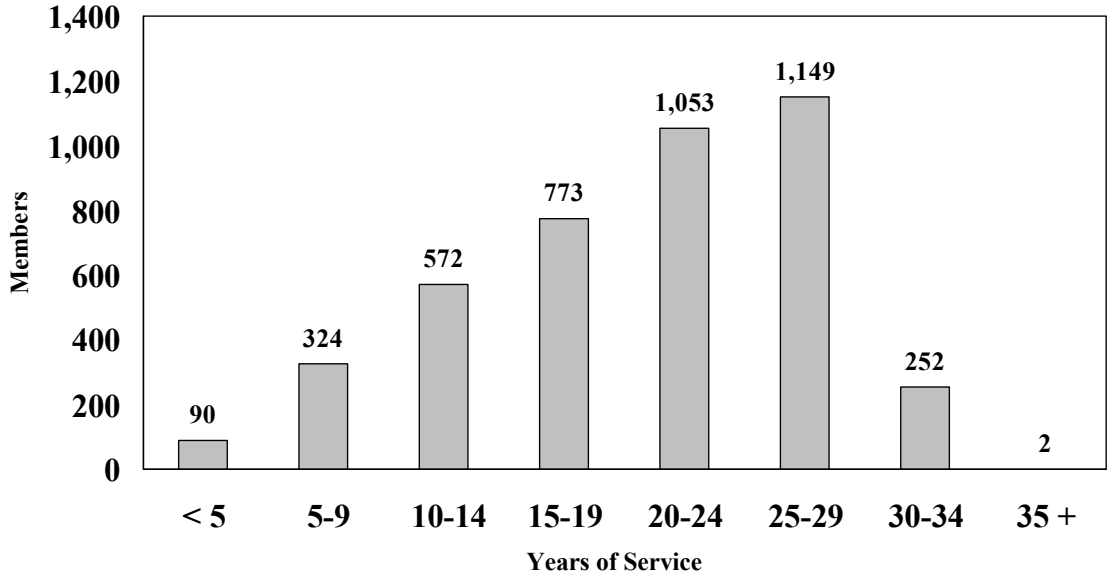
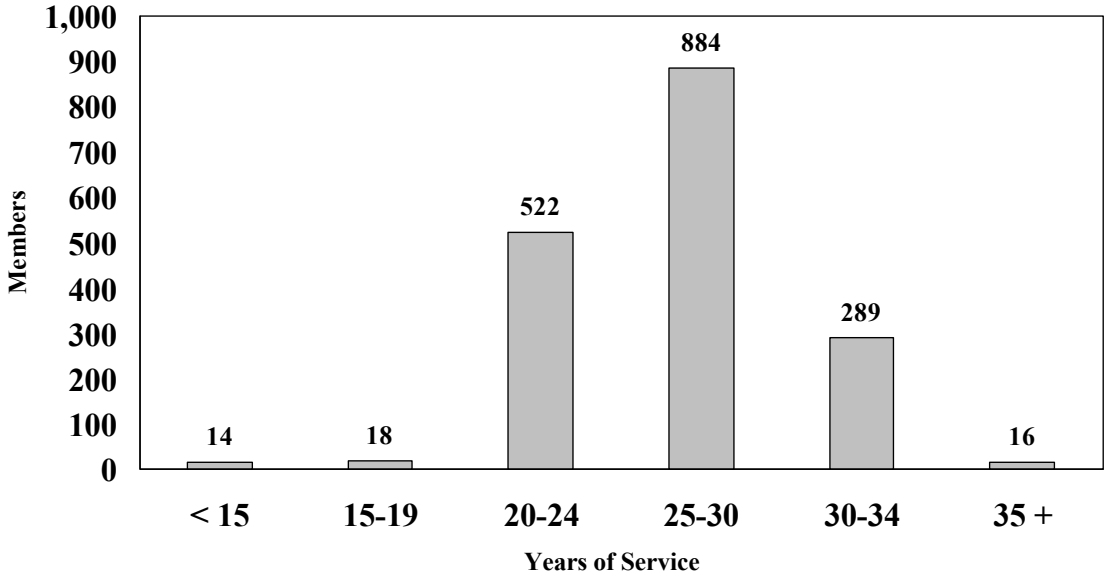


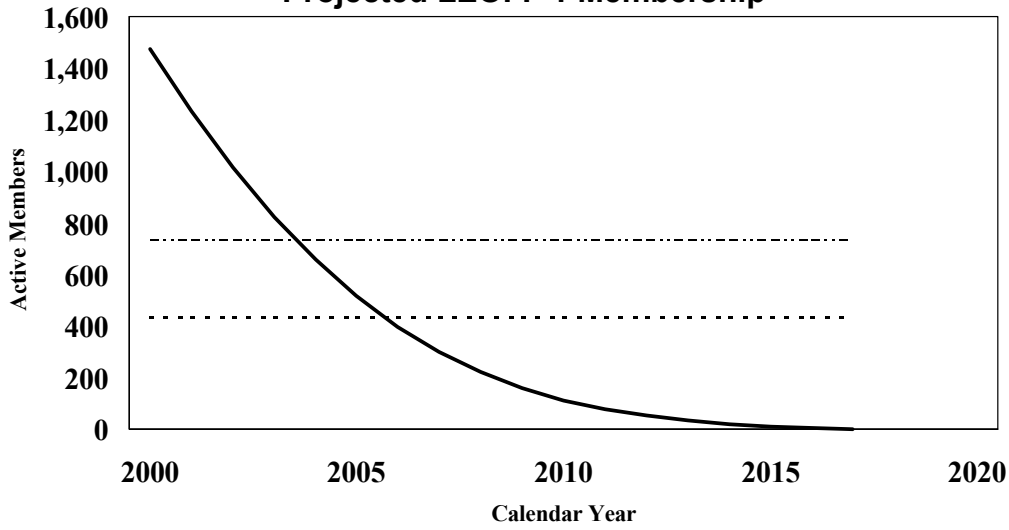
Figure 11
LEOFF 1 Active Members' Years of Service
(As of December 31, 1999)



Given the past history, it would seem the current membership is more likely moving toward service retirement as the norm rather than to disability retirement. More striking is what is to occur in the future.

Figure 12 shows the projected active LEOFF 1 membership from the year 2000 to 2017, represented by the solid line. The broken line represents 50 percent of the projected membership in the year 2000, and the dotted line represents 75 percent of this same membership. As can be seen, by approximately June 2003, half of the current active membership is forecasted to have retired. By approximately the last quarter of the year 2005, three-quarters of this membership is expected to have retired.

Figure 12
Projected LEOFF 1 Membership



Currently, 52 percent of the active membership is under the jurisdiction of the First Class City disability boards; 32 percent of the membership is under the jurisdiction of the County disability boards; and the remaining 16 percent of the membership is under the jurisdiction of the disability boards for cities having 20,000 or more population. Of the First Class Cities, 75 percent of this membership are employed by the cities of Seattle, Spokane and Tacoma.

Presently, 420 individuals are, by law, designated for membership on the 80 disability boards. Of this number, 180 of the board members are public officials.

Administering the Medical Benefit:

RCW 41.26.150 states ". . . the employer shall pay for the active or retired member the necessary medical services not payable from some other source. . . ." The other source refers to any insurance benefits available. The same section also states "The disability board shall designate the medical services available to any sick or disabled member." The definition section of the LEOFF chapter contains a specific list of "minimum services to be provided."

Most medical services would be covered by insurance and performed directly by a physician. Where the services are covered by an insurance contract this process is no different than that for any active or retired employee with full coverage. Employees and employers are quite familiar with this process.

The long term care benefit differs in many respects. Optional forms of care may be available and there may be no insurance company in the process to provide limitations of coverage, or assist in managing services. More assessment and discretion may be required to serve the member and the employer.

Medicare

Most LEOFF 1 retirees have Medicare coverage either through direct payroll contributions or eligibility through the Medicare coverage of a spouse. In 1995, the earlier report on LEOFF 1 medical benefits stressed the importance of Medicare in reducing the expense of medical costs for persons age 65 or older. The basis for this is found in RCW 41.26.150(2) which states:

> *"The medical services payable under this section will be reduced by any amount received or eligible to be received by the member under workers' compensation, social security including the changes incorporated under Public Law 89-97 [i.e. Medicare], insurance provided by another employer, other pension plans, or any other similar source. Failure to apply for coverage if otherwise eligible under the provisions of Public Law 89-97 shall not be deemed a refusal of payment of benefits thereby enabling the collection of charges under the provisions of this chapter."*

This language is what is termed a "coordination of benefits" clause common to the insurance industry. In other words, the employer will pay only that part of the medical cost liability, if any, that remains after any other coverage, paid or not, the LEOFF 1 member is entitled to receive. This explicitly includes Medicare.

A later clause [RCW 41.26.150(5)] states:

> *"Any employer under this chapter may, at its discretion, elect to reimburse a retired former employee under this chapter for premiums the retired former employee has paid for medical insurance that supplements medicare, including premiums the retired former employee has paid for medicare part B coverage."* [4]

As already noted, if the LEOFF member is covered under Social Security, the contributions were made for Medicare and the person is automatically eligible upon attaining age 65. The person is also eligible at age 65, if his or her spouse is or will be eligible for Medicare. Upon attaining age 65, Medicare Part A becomes effective, covering certain hospital and skilled nursing needs. No premium for this coverage is required for eligible persons. Medicare Part B, on the other hand, requires payment of a monthly premium - currently $45.50 per month. This is insurance, in part, for certain non-hospital medical coverage, medical equipment, etc. If the person is not otherwise eligible for Part A, a premium may be paid to become eligible. Currently, this premium is $301 per month.

Because of the impact Medicare has on the medical costs of retirees who are age 65 or older, it is important that the employer give serious thought to be sure these retirees are covered under Medicare. To drive home the effect of Medicare, the consultant provides the following claims costs for those age 65 or older:

Monthly Cost Without Medicare: $674
Monthly Cost With Medicare: $231

Obviously, the difference of $443 per month is significant. Even if the employer were to pay the Part A and Part B premiums of $301 and $45.50 per month, respectively, the savings would still be $96.50 per month. For all employers to pay the Part B premium of the retirees age 65 and over is illustrated in Table 21, given no deaths and no change in the current $45.50 per month.

[4] *The intent of RCW 41.26.150(5) is currently being brought before the Court of Appeals. Bremerton does not pay the Part B premiums for its LEOFF 1 members eligible for Medicare. In its suit (Bremerton Public Safety Assoc., et al, vs .City of Bremerton), the plaintiffs held that the city should make the payments. The trial court ruled in favor of the city.*

Table 21
Payment of Part B Premium

Year	Retiree Age 65 and Over	Total Payment ($ in Millions)
2000	2,349	$1.3
2001	2,528	1.4
2002	2,730	1.5
2003	2,966	1.6
2004	3,176	1.7
2005	3,414	1.9